RESIDENT/INDIVIDUAL RELOCATION PLANNING AND PROCEDURE MANUAL

NURSING HOMES – HFS 132

FACILITIES SERVING PEOPLE WITH DEVELOPMENTAL DISABILITIES –HFS 134

COMMUNITY BASED RESIDENTIAL FACILITIES – HFS 83

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Disability and Elder Services
Bureau of Quality Assurance
PO Box 2969
Madison WI 53701-2969

May 17, 2004

Resident Relocation Planning Process

Nursing Homes
Facilities Serving People with Developmental Disabilities
and
Community Based Residential Facilities

TABLE OF CONTENTS

WISCONSIN DEPARTMENT OF HEALTH AND FAMILY SERVICES
DIVISION OF DISABILITY AND ELDER SERVICES
BUREAU OF QUALITY ASSURANCE
May 17, 2004

RESIDENT RELOCATION PLANNING PROCESS
Nursing Homes, Facilities serving people with Developmental Disabilities and Community Based Residential Facilities

The purpose of this manual is:

- To identify the statutory authority for relocation of residents.
- To describe the different types of facility occurrences resulting in relocation plans. (Voluntary closing, downsizing, changing the level of services or means of reimbursement or Departmental enforcement actions).
- To detail the steps in the review and approval of the relocation plan process.
- To provide information about relocation and onsite monitoring activities throughout the relocation process.
- To facilitate the monitoring of placement and status of each relocated resident.
- To ensure that the rights of each resident is observed during the relocation process.

I. STATUTORY BACKGROUND

a. The Department of Health and Family Services (Department) has statutory authority under sec. 50.03(14)(a), Wis. Stats., to provide, direct or arrange for relocation planning, placement and implementation services in order to minimize the trauma associated with the relocation of residents and ensure the orderly relocation of residents.

b. Section 50.03(5m)(a)1.- 6., Wis. Stats., authorizes the Department to remove residents from any facility licensed under this chapter when any of the following conditions exist:

1. The facility is operating without a license.

2. The Department has suspended or revoked the existing license of the facility.

3. The Department has initiated revocation procedures under sec. 50.03(5), Wis. Stats., and has determined that the lives, health, safety or welfare of the residents cannot be adequately assured pending a full hearing on license revocation.

4. The facility has requested the aid of the Department in the relocation of the resident and the Department finds that the resident consents to relocate or that the move is made for valid medical reasons or for the welfare of the resident or of other residents.

5. The facility is closing, intends to close or is changing its type or level of services or means of reimbursement accepted and will relocate at least 5 residents or 5% of the residents, whichever is greater.

6. The Department determines that an emergency exists which requires immediate relocation of the resident. An emergency is a situation, physical condition or one or more practices, methods or operations, which presents imminent danger of death or serious physical or mental harm to a resident of a facility.

c. During any relocation activity, the facility is required to continue to provide care and treatment in compliance with its licensure mandates in Ch. 50, Wis. Stats., HFS 132, HFS 134, HFS 83 and Medicare/Medicaid certification requirements, if applicable. Facilities relocating residents because of enforcement action shall nonetheless be expected to provide services according to applicable state and federal regulatory requirements.

II. GENERAL INFORMATION

Different types of occurrences result in relocation plans:

1. Voluntary closing of a facility, downsizing, changing the level of services or means of reimbursement; or
2. Relocation due to departmental enforcement actions.

When a facility makes a voluntary decision to close, downsize or change the level of services or means of reimbursement, the facility is required by sec. 50.03(14)(c), Wis. Stats., to notify the Department in writing of its intention to relocate residents and submit a preliminary relocation plan.

Likewise, if the Department determines that a facility's continued Medicaid and/or Medicare certification, or its state licensure is in jeopardy, the Department requires the facility to begin the discharge planning process in the event it cannot come into regulatory compliance. The facility must comply with the same requirements relating to resident relocation under sec. 50.03(14), Wis. Stats., noted above. In enforcement actions, the Department will provide a notice to the facility requiring submission of a preliminary resident relocation plan (see sample - **attachment #1**).

In both instances, the facility must obtain prior approval of a resident relocation plan from the Department before any residents may be relocated. However, any resident wishing to leave the facility for another placement is free to do so. Once approval is obtained, Department staff are available to offer assistance or guidance to minimize relocation misunderstanding and confusion. Department staff will monitor the relocation process.

Section 50.03(14)(e), Wis. Stats., provides that the effective date of the closing may not be earlier than:

1. **90 days** from the date a relocation plan is approved by the Department if **5 to 50** residents are to be relocated; **OR**
2. **120 days** from the date a relocation plan is approved by the Department if **more than 50** residents are to be relocated.

The Department has established a DHFS relocation plan review team comprised of the following persons/agencies:

- The Bureau of Quality Assurance (BQA), Provider Regulation & Quality Improvement (PRQI) Consultants, who have lead responsibility for this team;
- The Bureau of Quality Assurance Regional Field Operations Director and/or Regional Field Operations Supervisor (BQA);
- The Bureau on Aging and Long Term Care Resources (BALTCR);
- The Bureau of Developmental Disabilities Services (BDDS);
- The Bureau of Mental Health and Substance Abuse Services (MHSAS); and
- The Office of Legal Counsel (OLC), for consultation, as needed.

The Regional Ombudsmen from the Wisconsin Board on Aging and Long Term Care (BOALTC) will also participate in the plan review team efforts.

This team will effectively and carefully review the facility's resident relocation plan to help the facility minimize the effects of transfer stress on residents.

III. PROCEDURES FOR SUBMISSION AND REVIEW OF A RELOCATION PLAN

FACILITY

1. Submit a written notice of the facility's intention to relocate residents, along with a preliminary plan.

   - Nursing homes, Facilities Serving People with Developmental Disabilities and Community Based Residential Facilities (9 bed or more) should submit their relocation plan to the attention of the Social Services Consultant, Provider Regulation and Quality Improvement, BQA:

     Dept. of Health & Family Services
     Attn: Dinh Tran, Social Services Consultant
     Bureau of Quality Assurance
     Provider Regulation and Quality Improvement Section
     P.O. Box 2969
     Madison, WI 53701-2969
     (608) 266-6646

   - CBRFs (8 bed or less) should submit the relocation plan to the attention of the Assisted Living Section Regional Field Operations Supervisor, BQA. (See **attachment #2** for the list of BQA regional office and addresses and telephone numbers.)

   This plan, at a minimum, should include:

   a. The proposed date of closing or changing of the type or level of services or means of reimbursement,
   b. A description of how the facility will involve the county departments of social services/human services in the planning for the relocation of residents.
   c. A proposed timetable for planning and implementing resident relocations.

d. The resources, policies and procedures that the facility will provide or arrange for in order to plan and implement the relocations.

e. A list of the residents to be relocated and their current levels of care and the name of the person's county of responsibility.

f. A brief description of each of the resident's needs or conditions; include a notation if the resident needs specialized services.

g. A list of residents who have guardians and the current names, addresses and phone numbers of the guardians.

h. A list of all residents who have an ***activated*** Power of Attorney for Health Care, pursuant to sec. 155.30 of the Wis. Stats., and the current name, address and phone number of the agent.

i. A list of all residents who executed a Durable Power of Attorney under sec. 243.07, Wis. Stats., after May 1, 1982 and prior to April 28, 1990, that specifies health care decisions.

j. A list of residents protectively placed in the facility under Chapter 55, Wis. Stats. Note: This should be in place for every resident who has a legal guardian, unless the resident has been in the facility for less than 3 months and was admitted from a hospital for recuperative care.

k. A list of all residents who may need legal representation.

l. A sample draft of the notice of intent to close the facility to be sent to residents/families.

m. A sample draft of the discharge notices to residents once the resident's placement has been decided by the resident/legal representative. These items must *all* be included in the notice:

- Reason for discharge
- Effective date of discharge
- Location to which the resident will be discharged
- Statement that the resident has the right to appeal this action to the State of Wisconsin
- Provision of the name, address and telephone number of the Long Term Care Regional Ombudsman. If the resident is determined to be chronically mentally ill or developmentally disabled, the facility must also list the state's protection and advocacy agency, the Wisconsin Coalition for Advocacy (WCA).

n. A description of how the facility will consult the physician regarding the effects of the potential relocation on the residents' health and how the facility will involve each resident's physician in the resident's planning conference.

o. Information regarding how the facility will work with residents and their families/guardians to resolve complaints or concerns.

p. The procedure that will be implemented to secure an appropriate alternate living arrangement for each individual, including the post-discharge plan of care or individual service plan required under 42 CFR 483.20(L)(3) to include the following:

- Resident's and family's preferences for care;

- How services should be accessed;
- How care should be coordinated if continuing treatment involves multiple caregivers;
- Identification of specific resident needs after discharge such as personal care, wound dressings, type of therapy, special diet, etc.
- Description of resident/caregiver education needs and ability to meet care needs after discharge.

q. A draft of the written notice of the discharge planning meeting to be sent to each resident/legal representative at least 7 days prior to the meeting day.

r. A sample notice required under HFS 132.54 in the event that the facility is approved to relocate residents within the facility during progress toward closing the building.

BQA RELOCATION LEAD

2. When a facility has submitted a relocation plan to the Department, several agencies must immediately be notified by telephone: the county(s) of responsibility, the county office on aging, various agencies within the Department, the Regional Ombudsman covering the facility, the appropriate office of WCA, etc. Notification may occur before the plan is submitted, but only with the agreement of the facility. Each agency will designate the appropriate person to be notified. When the BQA regional office is the primary contact point for the facility, the office should coordinate with the Social Services Consultant regarding notification of agencies.

3. Make and distribute copies to the following:

a. BQA regional office or central office, as needed

b. Bureau on Aging and Long Term Care Resources

c. Bureau of Developmental Disabilities (for residents with developmental disability)

d. Bureau of Mental Health and Substance Abuse Services (for residents with mental illness)

e. Board on Aging and Long Term Care (Regional Ombudsman)

f. Wisconsin Coalition for Advocacy for those residents with diagnosis of developmental disability or mental illness.

4. Complete initial review of submitted plan based on above criteria and consultation with other members of the relocation team. Respond to provider within 10 calendar days of receipt pursuant to sec. 50.03(14)(d), Wis. Stats. The Department's failure to provide a response within 10 days results in automatic approval of the relocation plan. Determine whether all statutory required components are present and appropriate. Use attachments #3, #4 and #5 to assure all required data are received and meet Chapter 50 of the Wis. Stats. **Attachment #3** is a relocation plan review checklist used to determine whether all the required components from sec. 50.03(14) are present. **Attachment #4** is a summary of state and federal regulatory requirements relative to resident relocation. **Attachment #5** describes what reviewers should look for in the relocation plan as it relates to sec. 50.03(14) requirements.

5. Consult with provider until all components of relocation plan are complete and acceptable. **(Attachment #6** may be used)
6. Notify provider in writing when relocation plan is approved (**attachment #7**).

IV. Onsite Relocation Monitoring Activities

The following monitoring activities will be implemented by the Department and BOALTC once the plan is approved and the relocation starts.

BQA/BOALTC RELOCATION LEAD

1. Set up initial relocation information meetings at the facility.
   - **a.** Set up meeting with facility staff to discuss the relocation and discharge process, roles of the various relocation team members and resources available.
   - **b.** Set up meeting with residents, family members and guardians to discuss the relocation and discharge process, the rights of the residents, roles of the various relocation team members and resources available.

RELOCATION TEAM

2. Make arrangements with the appropriate county social/human services unit to provide assessments and functional screens for all residents.

3. Develop a schedule to monitor the relocation plan, either via onsite visits or via teleconference calls. Discuss status of each resident's relocation plan, any barriers to placement, potential placements, choices, options, etc. In addition, discuss any additional information needed from any of the team members (e.g. PASARR screening, input from guardian, etc.)

FACILITY

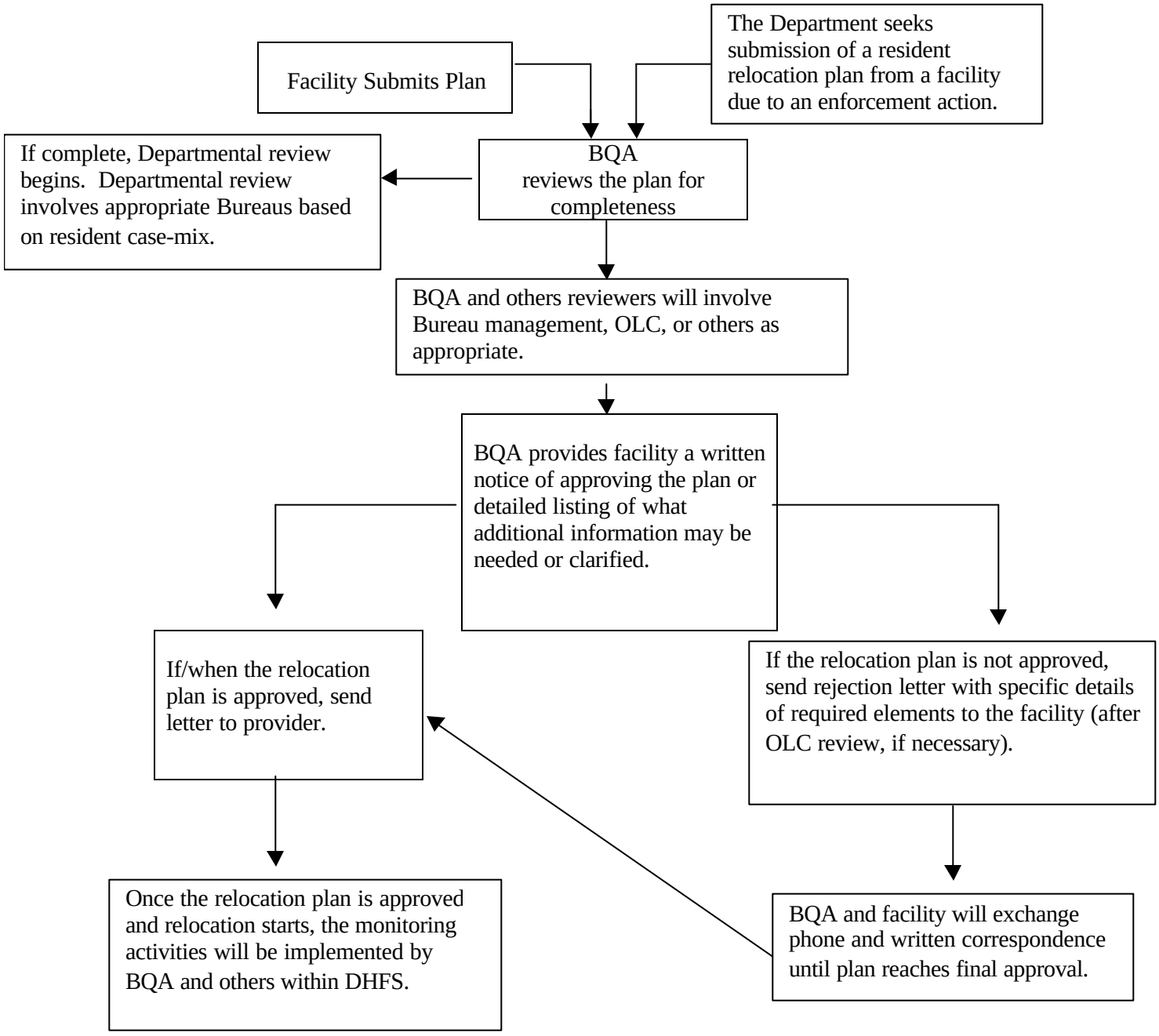
4. Submit weekly reports on all resident transfers, discharges to the community or hospital, and deaths. Include status of the relocation process as it pertains to residents, or cases involving unresolved or pending guardianship issues to BQA. The BQA Relocation Team Coordinator will distribute reports to other team members as appropriate.

5. Document in each resident's care plan the changes and adjustments in care, treatment and activities of daily living necessary for the resident to make a successful transition to a new placement and to ameliorate the negative affects of relocation.

6. Attach the BQA's Relocation Best Practices on top of the resident's files at the time of transfer of a resident to the new facility.

7. Notify BQA when the last resident has left the facility. Return license to BQA, with a complete listing of discharges (date and where relocated to).

Flow Chart of Resident Relocation Plan Approval Process



Attachment #1- Notice to the Facility-

Requirement of Submission for a Preliminary Resident Relocation Plan

(DATE)

INSIDE ADDRESS

RELOCATION PLAN – PLEASE READ CAREFULLY

Dear ADMINISTRATOR:

The Bureau of Quality Assurance (BQA) has recommended to the federal Centers for Medicare and Medicaid Services (CMS) and the state Division of Health Care Financing that your participation in the Medicare and Medicaid reimbursement programs be terminated effective (DATE) if your facility is not in substantial compliance by that date. After the termination of certification, Medicare and Medicaid reimbursement will continue for only 30 days. The facility is responsible for the care of the residents and the cost of the care of any Title 18 or Title 19 residents who remain in the facility after (30 DAYS AFTER THE TERMINATION DATE).

Pursuant to sec. 50.03(5m)(a) and (14), Wis. Stats., (NAME OF FACILITY) is required to submit a resident relocation plan as a contingency. This plan must be in accordance with the requirements of sec. 50.03(14), Wis. Stats. The facility must also comply with requirements under sec. HFS 132.53(3), Wisconsin Administrative Code and federal requirements under 42 CFR sec. 483.12(a)(4) through (7) regarding discharge procedures and notices for residents.

Enclosed please find the document "Regulatory Requirements Relative to Resident Relocation" that outlines these requirements. The plan must be approved by the Department prior to the relocation of any residents. The completion of this plan does not extend the timeframe for achieving substantial compliance with state and federal requirements.

Pursuant to these requirements, the resident relocation plan must include all information and data referenced in the "Regulatory Requirements Relative to Resident Relocation" and must be submitted to the Department no later than (DATE).

If the facility is a nursing home, facility serving people with developmental disabilities or a community based residential facility (9 bed or more), submit the plan to:

Dept. of Health & Family Services
Attn: Dinh Tran, Social Services Consultant
Bureau of Quality Assurance
Provider Regulation and Quality Improvement Section
P.O. Box 2969
Madison, WI 53701-2969

If the facility is a community based residential facility (8 bed or less), submit the relocation plan to the attention of the Regional Field Operations Supervisor for the region the facility is located within.

The Bureau of Quality Assurance staff will review your plan for the relocation of residents and will continue working with you to develop an acceptable plan if necessary. We anticipate that the Department will monitor your activities in arranging the appropriate transfer of residents.

As a result of this licensure action and the requirement that the facility develop a relocation plan for its residents, the Department is attaching a condition to the facility's existing license, as authorized under s. 50.03(4)(e), Stats. That condition is as follows:

> "The facility must inform any prospective resident, both orally and in writing, that the facility is being required to develop a plan for the relocation of its residents, and that admission to the facility as a resident may result in the prospective resident's relocation pursuant to the relocation plan."

If you have any questions regarding these relocation plan procedures, please call _____, at _____.

Sincerely,

_____
Bureau of Quality Assurance
_____

Attachment

CC w/o attachment:	Susan Schroeder	Sharon Rickords	Tom Swant
	Otis Woods	Dinh Tran	Dan Zimmerman
	Jan Eakins	Cheryl Bell-Marek	Claudia Stine
	RFOD's	Sharon Hron	Gail Hansen

Attachment #2

Bureau of Quality Assurance - Regional Offices

Regional Field Operations Director (RFOD)
Northeastern (Green Bay) Regional Office
200 North Jefferson Street, Suite 211
Green Bay, WI 54301
(920) 448-5249

RFOD
Northern (Rhinelander) Regional Office
1853 North Stevens, Suite B
Rhinelander, WI 54501
(715) 365-2802

RFOD
Southeastern (Milwaukee) Regional Office
819 North 6th Street, Room 210
Milwaukee, WI 53203-1606
(414) 227-4908

RFOD
Southern (Madison) Regional Office
2917 International Lane, Suite 210
Madison, WI 53704
(608) 243-2374

RFOD
Western (Eau Claire) Regional Office
610 Gibson Street, Suite 1
Eau Claire, WI 54701-3687
(715) 836-4753

Attachment #3-

Relocation Plan Review Checklist

Section 50.03(14), Wis. Stats.

_	(b)	County Departments
_	(c)1	30 day written notice
_	(c)2	Complaints
_	(c)3	Appropriate Alternative Placement
_	(c)4	Physician Consult
_	(c)5	Planning Conference to develop individual relocation plan
_	(c)6	Implement individual relocation plan
_	(c)7	Notify Department
_		facts requiring relocation
_		proposed date of closing, changing level of service or means of reimbursement
_	(c)8a	Timetable for planning and implementation of relocations
_		Resources, policies and procedures to plan and implement
_	(c)8b	Resident list
_		Current Level of Care
_		Special needs/conditions
_	(c)8c	Names of residents with guardians
_		Guardian names and addresses
_	(c)8d	Names of residents protectively placed under Ch. 55
_	(c)8e	Names of residents whom facility believes to be incompetent
_	(e)	Closing date
_		relocating 5 to 50 residents no earlier than 90 days from plan approval
_		relocating 50 plus residents no earlier than 120 days from plan approval

Attachment #4

REGULATORY REQUIREMENTS RELATIVE TO RESIDENT RELOCATION

In planning for resident relocation, please be aware that the following statutory, state code, and federal requirements must be met.

1. Section 50.09(1)(j), Wis. Stats. states that residents have the right to "be transferred or discharged, and be given reasonable advance notice of any planned transfer or discharge, and an explanation of the need for and alternative to such transfer or discharge. The facility to which the resident is to be transferred must have accepted the resident for transfer, except in a medical emergency."

2. Section 50.03(14), Wis. Stats. states:

"(a) The department may provide, direct or arrange for relocation planning, placement and implementation services in order to minimize the trauma associated with the relocation of residents and to ensure the orderly relocation of residents.

(b) The county departments of the county in which the facility is located that are responsible for providing services under s. 46.215(1)(L), 46.22(1)(b)1.c., 51.42 or 51.437 shall participate in the development and implementation of individual relocation plans. Any county department of another county shall participate in the development and implementation of individual relocation plans in place of the county department of the county in which the facility is located, if the county department accepts responsibility for the resident or is delegated responsibility for the resident by the department or by a court.

(c) The facility shall:

1. Provide *at least* (italics added) 30 days written notice prior to relocation to each resident who is to be relocated, to the resident's guardian, if any, and to a member of the resident's family, if practicable, unless the resident requests that notice to the family be withheld.

2. Attempt to resolve complaints from residents under this section.

3. Identify and, to the greatest extent practicable, attempt to secure an appropriate alternate placement for each resident to be relocated.

4. Consult the resident's physician on the proposed relocation's effect on the resident's health.

5. Hold a planning conference at which an individual relocation plan will be developed with the resident, with the resident's guardian, if any, and with a member of the resident's family, if practicable, unless the resident requests that a family member not be present.

6. Implement the individual relocation plan developed under subd. 5.

7. Notify the department of its intention to relocate residents. The notice shall state the facts requiring the proposed relocation of residents and the proposed date of closing or changing of the type or level of services or means of reimbursement.

8. At the time the facility notifies the department under subd. 7., submit to the department a preliminary plan that includes:

a. The proposed timetable for planning and implementation of relocations and the resources, policies and procedures that the facility will provide or arrange in order to plan and implement the relocations.

b. A list of the residents to be relocated and their current levels of care and a brief description of any special needs or conditions.

c. Indicate which residents have guardians and the guardian's names and addresses.

d. A list of which residents have been protectively placed under Ch. 55.

e. A list of the residents whom the facility believes to be incompetent.

(d) If the preliminary plan is disapproved, the department shall notify the facility within 10 days after receiving the preliminary plan under par. (c)8. If the department does not notify the facility of disapproval, the plan is deemed approved. If the department disapproves the preliminary plan, it shall, within 10 days of notifying the facility, begin working with the facility to modify the disapproved plan. No residents may be relocated until the department approves the preliminary plan or until a modified plan is agreed upon. If a plan is not approved or agreed upon within 30 days of receipt of the notice of relocation, the department may impose a plan that the facility shall carry out. Failure to submit, gain approval for or implement a plan in a timely fashion is not a basis for a facility to declare an emergency under sub. 5m(a)6. or to relocate any resident under sub. (5m)(g).

(e) Upon approval of, agreement to or imposition of a plan for relocation, the facility shall establish a date of closing or changing of the type or level of services or means of reimbursement and shall notify the department of the date. The date may not be earlier than 90 days from the date of approval, agreement or imposition if 5 to 50 residents will be relocated, or 120 days from the date of approval, agreement or imposition if more than 50 residents will be relocated."

3. A facility licensed under ch. HFS 132, Wis. Admin. Code, must comply with the following requirements:

> "HFS 132.54 Transfer within the facility. Prior to any transfer of a resident between rooms or beds within a facility, the resident or guardian, if any, and any other person designated by the resident shall be given reasonable notice and an explanation of the reasons for transfer. Transfer of a resident between rooms or beds within a facility may be made only for medical reasons or for the resident's welfare or the welfare of other residents or as permitted under s. HFS 132.31 (1)(p)1."

"HFS 132.53(3) PROCEDURES. (a) Notice. The facility shall provide a resident, the resident's physician and, if known, an immediate family member or legal counsel, guardian, relative or other responsible person at least 30 days notice of transfer or discharge under sub. (2)(a) 2. to 10., and the reasons for the transfer or discharge, unless the continued presence of the resident endangers the health, safety or welfare of the resident or other residents. The notice shall also contain the name, address and telephone number of the Board on Aging and Long-Term Care. For a resident with developmental disability or mental illness, the notice shall contain the mailing address and telephone number of the protection and advocacy agency designated under s. 51.62(2)(a), Stats.

(b) Planning Conference. 1. Unless circumstances posing a danger to the health, safety or welfare of a resident require otherwise, at least 7 days before the planning conference required by subd. 2., the resident, guardian, if any, any appropriate county agency, and others designated by the resident, including the resident's physician, shall be given a notice containing the time and place of the conference, a statement informing the resident that any persons of the resident's choice may attend the conference, and the procedure for submitting a complaint to the department.

2. Unless the resident is receiving respite care or unless precluded by circumstances posing a danger to the health, safety or welfare of a resident, prior to any involuntary transfer or discharge under sub. (2)(a)2. to 10., a planning conference shall be held at least 14 days before transfer or discharge with the resident, guardian, if any, any appropriate county agency, and others designated by the resident, including the resident's physician, to review the need for relocation, assess the effect of relocation on the resident, discuss alternative placements and develop a relocation plan which includes at least those activities listed in subd. 3.

3. Transfer and discharge activities shall include:

a. Counseling regarding the impending transfer or discharge;

b. The opportunity for the resident to make at least one visit to the potential alternative placement, if any, including a meeting with that facility's admissions staff, unless medically contraindicated or waived by the resident;

c. Assistance in moving the resident and the resident's belongings and funds to the new facility or quarters; and

d. Provisions for needed medications and treatments during relocation.

4. A resident who is transferred or discharged at the resident's request shall be advised of the assistance required by subd. 3 and shall be provided with that assistance upon request.

(c) Records. Upon transfer or discharge of a resident, the documents required by s. HFS 132.45(L)(1) and (6)(h) shall be prepared and provided to the facility admitting the resident, along with any other information about the resident needed by the admitting facility."

4. Federally certified nursing home facilities must comply with the following federal regulations in addition to state requirements for relocation planning.

Section 42CFR 483.12(a)(4) through (7) states the following:

"(a)(4) Notice before transfer. Before a facility transfers or discharges a resident, the facility must--

(i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.

(ii) Record the reasons in the resident's clinical record; and

(iii) Include in the notice the items described in paragraph (a)(6) of this section.

(a)(5) Timing of the notice.

(i) Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.

(ii) Notice may be made as soon as practicable before transfer or discharge when--

(A) The safety of individuals in the facility would be endangered, under paragraph (a)(2)(iii) of this section;

(B) The health of individuals in the facility would be endangered, under (a)(2)(iv) of this section;

(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(ii) of this section;

(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(i) of this section; or

(E) A resident has not resided in the facility for 30 days.

(a)(6) Contents of the notice. The written notice specified in paragraph (a)(4) of this section must include the following:

(i) The reason for transfer or discharge;

(ii) The effective date of transfer or discharge;

(iii) The location to which the resident is transferred or discharged;

(iv) A statement that the resident has the right to appeal the action to the State;

(v) The name, address and telephone number of the State Long Term Care Ombudsman;

(vi) For nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and

(vii) For nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.

(a)(7) Orientation for transfer or discharge. A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

Section 42 CFR 483.20(L)(3) states the following:

"(L)(3) A post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment." A post-discharge plan of care means the discharge planning process which includes: assessing continuing care needs and developing a plan designed to ensure the individual's needs will be met after discharge from the facility into the community or other appropriate settings.

5. A facility licensed under ch. HFS 134, Wis. Admin. Code, must comply with the following requirements:

"HFS 134.53(4)(b) Notice. The facility shall provide the resident, the resident's family or guardian or other responsible person, the appropriate county department designated under s. 46.23, 51.42 or 51.437, Stats., and, if appropriate, the resident's physician, with at least 30 days notice before making a permanent removal under sub. (2)(b), except under sub (2)(b)5 or if the continued presence of the resident endangers his or her health, safety or welfare or that of other residents.

(c) Removal procedures. 1. Unless circumstances posing a danger to the health, safety or welfare of a resident require otherwise, at least 7 days before the planning conference required by subd. 2., the resident, guardian, if any, the appropriate county department designated under s. 46.23, 51.42 or 51.437, Stats., and any person designated by the resident, including the resident's physician, shall be given a notice containing the time and place of the conference, a statement informing the resident that any persons of the resident's choice may attend the conference and the procedure for submitting a complaint to the department about the prospective removal.

2. Unless the resident is receiving respite care or unless precluded by circumstances posing a danger to the health, safety or welfare of a resident, prior to any permanent involuntary removal under sub. (2)(b), a planning conference shall be held at least 14 days before relocation with the resident, the resident's guardian, if any, any appropriate county agency and any persons designated by the resident, including the resident's physician or the facility QMRP, to review the need for relocation, assess the effect of relocation on the resident, discuss alternative placements and develop a relocation plan which includes at least those activities listed in subd. 3.

3. Relocation activities shall include:

a. Counseling the resident about the impending relocation;

b. Making arrangements for the resident to make at least one visit to the potential alternative placement facility and to meet with that facility's admissions staff, unless this is medically contraindicated or the resident chooses not to make the visit;

c. Providing assistance in moving the resident and the resident's belongings and funds to the new facility or quarters; and

d. Making sure that the resident receives needed medications and treatments during relocation.

(d) Transfer and discharge records. Upon relocation of a resident, the documents required by s. HFS 134.47(4)(k) shall be prepared and provided to the facility admitting the resident, along with any other information about the resident needed by the admitting facility. When a resident is permanently released, the facility shall prepare and place in the resident's record a summary of habilitative, rehabilitative, medical, emotional, social and cognitive findings and progress and plans for care."

6. Federally certified facilities, Intermediate Care Facilities serving people with Mental Retardation (ICF's/MR) must comply with the following federal regulations in addition to state requirements for relocation planning.

Section CFR 483.440(b)(4)(i) through (b)(5)(ii) states the following:

"(b)(4) If a client is to be either transferred or discharged, the facility must--

(i) Have documentation in the client's record that the client was transferred or discharged for good cause; and

(ii) Provide a reasonable time to prepare the client and his or her parents or guardian for the transfer or discharge (except in emergencies).

(b)(5) At the time of the discharge, the facility must --

(i) Develop a final summary of the client's developmental, behavioral, social, health and nutritional status and, with the consent of the client, parents (if the client is a minor) or legal guardian, provide a copy to authorized persons and agencies; and

(ii) Provide a post-discharge plan of care that will assist the client to adjust to the new living environment."

7. A facility licensed under ch. HFS 83, Wis. Admin. Code, must comply with the following requirements:

"HFS 83.18(2)(a) INFORMATION TO BE PROVIDED AT TIME OF TRANSFER OR DISCHARGE. At the time of transfer or discharge of a resident from a CBRF, the CBRF shall inform the resident and the resident's guardian, agent or designated representative that all of the following information is available upon request.

1. The name and address of the CBRF, the dates of admission and discharge or transfer from the CBRF, and the name and address of a person to contact for additional information.

2. Names and addresses of the resident's physician, dentist and other medical care providers.

3. Names and addresses of the resident's relatives, guardian, agent or designated representative who should be contacted regarding care or services to be provided to the resident, or in case of emergency.

4. Names and addresses of the resident's significant social or community contacts.

5. The resident's assessment and individualized service plan, or a summary of each.

6. The resident's current medications and dietary, nursing, physical and mental health needs if not included in the assessment or individualized service plan.

7. A statement of the resident's ambulatory status related to the classes of CBRF's under s. HFS 83.05 (2), the resident's evacuation capability under Table 83.42 and, where applicable, the need for an alternate emergency plan under s. HFS 83.42 (4).

8. The reason for the resident's transfer or discharge.

9. A description of how the resident and the resident's guardian, agent or designated representative was involved in discharge planning and a summary of the options discussed.

(b) If a resident being transferred or discharged or the resident's guardian, agent or designated representative, or the resident's new place of residence, requests information under par. (a) the CBRF shall provide that information in writing. The CBRF may require the resident or the resident's guardian, agent or designated representative to pay for any costs of reproduction."

"HFS 83.20(2)(b) DISCHARGE OR TRANSFER OF RESIDENT. 1. Except as provided in subd. 2., before a CBRF transfers or discharges a resident, the licensee shall give a 30 day written advance notice to the resident or the resident's guardian, designated representative or agent. The licensee shall provide to the resident or the resident's guardian, designated representative or agent an explanation of the need for or possible alternatives to the transfer or discharge, and shall provide assistance in relocating the resident. A living arrangement suitable to meet the needs of the resident shall be located prior to the transfer of the resident."

"HFS 83.20(2)(d) DEPARTMENT REVIEW OF DISCHARGE OR TRANSFER.
1. A resident or his or her guardian, agent or designated representative may request the department to review an involuntary discharge or transfer decision. Every notice of discharge or transfer under par. (b) to a resident or the resident's guardian, agent or designated representative shall be in writing and include all of the following:

a. A statement that the resident or his or her guardian, agent or designated representative may request the department to review any notice of involuntary discharge or transfer to determine if the discharge or transfer is in compliance with the provisions of this chapter and ch. 50 or 51, Stats. The statement shall include the list of prohibitions and exceptions under par. (c).

b. The name, address and telephone number of the department's division of community services' regional office which licenses the CBRF and the name of the regulation and licensing chief for that office.

2. If the resident or his or her guardian, agent or designated representative wants the department to review the discharge or transfer, that person shall send a letter to the department's division of community services' regional office that licenses the CBRF asking for a review of the decision and explaining why the discharge or transfer should not take place. The written request shall be postmarked no later then 7 days after receiving a notice of discharge or transfer from the CBRF. The resident or his or her guardian, agent or designated representative shall send a copy of the letter to the facility administrator at the same time he or she sends the letter to the department. If a timely request is sent to the department, the resident shall not be discharged or transferred from the CBRF until the department has completed its review of the decision and notified the resident or his or her guardian, agent or designated representative and the facility of its conclusion."

Questions regarding this regulatory summary should be directed to Dinh Tran, Social Services Consultant at (608) 266-6646.

Attachment #5

SECTION 50.03(14) REQUIREMENTS

The following are the key points in Wisconsin Statutes Section 50.03(14):

a.) The Department may **provide** , **direct** or **arrange for** relocation planning, placement and implementation services in order to minimize the transfer stress associated with the relocation of residents and **ensure** the orderly relocation of residents. This gives the Department the authority to monitor facility resident relocations and provide assistance when necessary.

b.) This section requires county involvement. The Office of Strategic Finance, DHFS, monitors and assures that county agencies identify a contact person in their organization for relocation questions, community assessments/placements and court assistance. Counties are the essential team members in coordinating funding and community placements.

c.1.) The Department reviews the discharge notices that are given to residents, guardians, agents and/or family members. Facilities often fail to include this in their original submittal and it must be included. The notice is reviewed for information on resident rights issues, how residents and families are involved, and adherence to state and federal discharge requirements.

c.2.) The notice must inform the resident, the legal representative and/or family (unless the resident refuses family involvement) how complaints regarding the relocation efforts will be resolved. Residents and/or families need to know to whom and how to voice a complaint to the facility. They also need to know how to contact the Ombudsman, Regional BQA office, and other appropriate advocacy groups such as Wisconsin Coalition for Advocacy.

c.3.) Residents must be given alternatives and choices about the placement. In addition, sec. HFS 132.53(3)(b), Wis. Admin. Code, requires that a resident be given an opportunity to visit the proposed alternate placement.

c.4.) Each resident's physician is to be consulted regarding the effect of the proposed relocation on the resident's health. If the facility plans to inform the physician of the relocation by a physician "notice", the Department will want to review that notice.

c.5.) Planning conferences for an individual resident are **essential** in his/her relocation and the Department will review this part of the plan in detail. A facility must assure adequate time is scheduled for these individual-planning conferences. These conferences will assist the resident with decision making, alternative placement, funding resources and related relocation issues. The facility should provide a schedule of conferences, participants, and topics of discussion, as well as time for follow up discharge planning contacts. County agencies should be involved in this planning.

Implementation of relocations are monitored by BQA staff. Updates and interventions are done as needed including complaint investigations if warranted.

c.7.) When a facility makes a voluntary decision to close or downsize or changes the level of services or means of reimbursement, the facility is required to notify the Department in writing of its plan to relocate residents, including a rationale for doing so and a projected date when the closing or change will occur. The problem is often the **date** of closing, based upon how many residents are being relocated. A facility needs to give a proposed date of closing that is realistic and reasonable in order to maintain resident health and safety while planning and implementing the orderly relocation of the residents..

c.8.a.) Review all dates and make a determination whether they are reasonable. The Department will review policies and procedures, including implementation processes, to determine whether they are realistic and provide sufficient protection to prevent transfer stress. The resident list is critical in reviewing what steps need to be implemented to meet needs, particularly for difficult residents or residents with dementia, residents who may depend on environmental familiarity, resident choices, desires for roommate changes or retention, etc.

c.8.b.) The Department will review the plan to assure all residents rights are respected and that residents are included in all relocation planning. Facilities must identify each resident's care level and supply a brief description of their care needs and their diagnoses. All residents are reviewed for diagnosis of mental illness, dementia, developmental disability, etc. regardless of legal decision-making ability, as well as those with activated Power of Attorney for Health Care (POAHC) or guardians.

c.8.c.) If the resident has a guardian, the facility needs to identify them by name, address and phone number. The relocation plan needs to describe how the guardian will be involved in this process.

c.8.d) The facility needs to provide a list of which residents have been protectively placed under Chapter 55 in the plan.

c.8.e.) Residents who may need legal representation are of primary concern. If an incapacitated resident has not executed a POAHC under Chapter 55 WI Stats., or does not have a guardian, the facility must initiate the guardianship process with the assistance of the county and the court system. Residents who may need legal representation but determined incapacitated cannot have the POAHC activated on their behalf at this time.

Residents who the facility believes to be incapacitated and need legal representation and who have earlier executed a POAHC document and appointed an agent, need to have their POAHC activated and the facility has to initiate this and involve that agent in the relocation planning. The facility must supply the Bureau the agent's name, address and phone number, and include a description as to how they will be involved in the plan. Persons with a diagnosis of chronic mental illness according to the DSM-4 **may not be relocated without a guardian in place.**

Note: In general, a durable power of attorney that specifies health care decisions authorizes the agent or attorney-in-fact to make informed decisions on behalf of the principal to accept, maintain, discontinue or refuse health care options if the principal is incapacitated. Wisconsin law first recognized the durability of powers of attorney (i.e., effectiveness after an agent becomes incapacitated) with the enactment of sec. 243.07(1), Stats. That law took effect on May 1, 1982.

A durable power of attorney (DPOA) may be a valid means to have designated a health care agent if it was executed prior to April 28, 1990 (the effective date of ch. 155, Wis. Stats). Such a DPOA may not, however, be sufficient to place someone in a nursing home or avoid other requirements of ch. 55 and 880, Stats.

DPOA executed after April 28, 1990 is not a valid way to designate a health care agent unless the instrument conforms to the requirements of ch. 155, Stats.

All residents should have a representative from their legal county of residence involved in their relocation plan. Residents who have been protectively placed in the facility by the county must have county interventions, as the court must protectively place them in their new facility.

Attachment #6

DENIAL LETTER

(DATE)

INSIDE ADDRESS

Dear ADMINISTRATOR:

On (DATE), the Department received the relocation plan to relocate residents from NAME OF FACILITY. The relocation plan is not approved as meeting the requirements of sec. 50.03(14), Stats. The following observations about the plan as submitted are made in connection with the Department's obligation under s. 50.03(14)(d), Stats., to work with a facility to modify a disapproved relocation plan.

1.
2.
3.

You are required to amend and resubmit the relocation plan, including the resident-specific information and information addressing the concerns listed above. Please refer to section 50.03(14)(d), Wisconsin Statutes, for all pertinent requirements.

Any projected notices that will be given to residents or families are to be reviewed by the Department before the plan is approved and implemented.

A facility relocating (# OF INDIVIDUALS) cannot select a closing date earlier than (#OF DAYS) from the date of Department approval of the relocation plan. A resident, however, may relocate voluntarily any time a resident wishes to do so.

The date of closing will be (#OF DAYS) after the relocation plan is approved by the Department or the day the last resident is relocated in accordance with the plan, whichever occurs first.

The (# OF LICENSED BEDS) will be automatically surrendered upon the date of closing.

The Bureau of Quality Assurance staff will review your plan for the relocation of residents and work with you to develop an acceptable plan. We anticipate that the Department will monitor your activities in arranging the appropriate transfer of residents.

If you have any questions, please notify _____, at _____.

Sincerely,

_____
Bureau of Quality Assurance
_____

CC :	Susan Schroeder	Sharon Rickords	Tom Swant
	Otis Woods	Dinh Tran	Dan Zimmerman
	Jan Eakins	Cheryl Bell-Marek	Claudia Stine
	RFOD's	Sharon Hron	Gail Hansen

Attachment #7

APPROVAL LETTER

(DATE)

INSIDE ADDRESS

Dear ADMINISTRATOR:

We received your letter and your proposed relocation plan for NAME OF FACILITY on (Date Received). After review of your relocation plan, we find it satisfactorily meets the intent of the requirements in sec. 50.03(14) of the Wisconsin Statutes. Therefore, your plan to relocate (# of Residents), with the full participation of the resident, guardian, family and county of responsibility is approved effective (Date of Approval) contingent upon the following conditions:

- A facility relocating (# of Individuals) cannot select a closing date earlier than (# of days) from the date of Departmental approval of the relocation plan. A resident, however, may relocate voluntarily any time the resident wishes to do so.

- Accordingly, the date of closing may not be earlier than (# of days) from the date of this letter of approval, unless the last resident voluntarily relocates or is relocated in accordance with the relocation plan earlier than (# of days). If the last resident relocates or is relocated earlier than (# of days), the date of closing will be the day following the date of that relocation.

- If resident relocation cannot be completed in accordance with the relocation plan within (# of days), the Department will extend the date of closing as necessary to ensure the orderly relocation of residents.

- The (# of Licensed Beds) will be automatically surrendered upon the date of closing.

Please submit weekly progress reports regarding the relocation of residents to this office and another copy to:

(APPROPRIATE BQA REGIONAL OFFICE ADDRESS)

We anticipate that the Department will monitor your activities in arranging the appropriate transfer of residents.

If you have any questions, please notify _____, at _____.

Sincerely,

_____
Bureau of Quality Assurance

CC : Susan Schroeder	Sharon Rickords	Tom Swant
Otis Woods	Dinh Tran	Dan Zimmerman
Jan Eakins	Cheryl Bell-Marek	Claudia Stine
RFOD's	Sharon Hron	Gail Hansen

Various Roles in Facility Closures

Role of the Bureau of Quality Assurance

Role of the BQA Relocation Team Coordinator

Ensure that facilities that are downsizing or closing follow Chapter 50 as it relates to resident relocation. Specific duties include:

- Approval of the relocation plan:
  - Review plan for completeness and determine whether all required components are in the plan
  - Assure that all residents' clinical needs, resident rights and legal issues are addressed in the relocation plan
  - Once the plan is complete, initiate departmental review. Departmental review involves appropriate Bureaus based on resident case-mix
  - Consult with BQA, other bureaus and agencies regarding the relocation plan
  - Work with facility to ensure completeness of the relocation plan
  - Approve relocation plan once it meets requirements of Chapter 50

- Monitoring of the on-site relocation activities:
  - Organize meetings at the facility with staff, residents and family members
  - Coordinate and organize efforts of the Onsite Relocation Team
  - Set up routine meetings of the relocation team at the facility
  - Serve as liaison between BQA, other members of the relocation team and the facility during the relocation process
  - Ensure communication and integrated implementation of the plan
  - Ensure that resident needs and preferences are met
  - Ensure that the facility follows the relocation plan; report any potential violations of ch. 50 or HFS 132, 134 and 83 to the BQA regional office
  - Ensure that the following issues are being looked at during the onsite monitoring visits:

    ⇒ Are residents being given opportunities to participate in their discharge plan?
    ⇒ Are counties being afforded the opportunity to fulfill their responsibilities in helping the residents relocate?
    ⇒ Is the plan implemented and maintained in a progressive manner?
    ⇒ Is the plan being followed?
    ⇒ Are there any areas of concern regarding items in the plan?

Board on Aging and Long Term Care

The Role of an Ombudsman

The Ombudsman's Resident Advocacy Role
During a Nursing Home or Group Home Closure

For Residents and Families

An Ombudsman can help:

- Provide you with the information you need to make an informed choice about a new placement for yourself or your loved one;
- Discuss with you various alternatives and possibilities for a new place;
- At your request, come with you/your family to your discharge-planning meeting with the facility to talk about what you would like to do;
- Represent you to make sure your rights and choices are honored during the time you are getting ready to move and in your new place;
- Make sure that you continue to get good care and treatment during this busy and unsettling time;
- Talk with you when you feel stressful or sad about leaving your friends, or apprehensive about going to a whole new situation with new people; and
- Visit you in your new place to make sure everything is going all right.

For Facility Staff:

An Ombudsman can help:

- Provide information and education regarding discharge planning, placement alternatives, the resident's rights and responsibilities during relocation;
- Serve as a link to other resources in the community, state and around the country;
- Consult with you and problem-solve how to meet the individual needs of each resident;
- Discuss placement alternatives with the resident/family;
- Accompany the resident/family to the discharge-planning conference you hold to help reach a solution that is agreeable to the resident (must be at the request or approval of the resident or legal representative);
- Work together with you to ensure that each resident's rights are observed during this critical time;
- Alert you to any care and treatment issues arising as residents move out and discuss possible resolution to these concerns; and
- Help you provide critical incidence stress debriefing to families, residents, and assist you in forming support groups for residents and staff during relocation.

Wisconsin Coalition for Advocacy, Inc.

Wisconsin Coalition for Advocacy, Inc. is the Protection and Advocacy System for people with mental and physical disabilities within the State of Wisconsin. We are authorized under various laws to receive information and advocate to protect the rights of people with disabilities. Among the highest priorities for WCA advocacy are assuring proper discharge planning for people with disabilities living in nursing homes and other facilities and assuring the availability of quality community services. Any resident with a disability or their family may request information from WCA or request WCA's assistance in advocating for a facility or government agency to meet community long-term support or other disability-related needs.

In addition to resident-focused information and advocacy services, WCA also provides technical assistance and information as needed to facility staff and other agencies about the legal framework and requirements of discharge planning and community placement options to residents and families.

To contact WCA in Milwaukee, call (414) 342-8700. To contact WCA in Madison, call 800-928-8778.

Role of the Bureau of Aging and Long Term Care Resources

As a member of the Onsite Relocation Team, the Bureau of Aging and Long Term Care Resources staff participate in the relocation process, working with county and facility staff over the course of the facility closing and resident relocation. The Bureau's role responsibilities include:

- Encourage county participation in the process of assessment and screening of residents for possible community relocation.

- Provide technical assistance and support to the County agency to secure funding to support service plans for nursing home residents who will be relocated to community settings.

- Provide assistance in service plan and/or resource development to the County agency staff and facility discharge planners.

- Ensure that those residents who are affected by the facility closing are given ample opportunity for community relocation and that they receive the information and support necessary to make an informed decision about community alternatives.

- Provide information to residents, family members, guardians and facility staff regarding funding limitations, eligibility criteria, and service alternatives allowable under Home and Community-Based Waivers programs managed by BALTCR.

- Follow-up with County staff to review a resident's community placements and work with monitoring agencies to assure eligibility and funding issues are resolved.

- Ensure staff from county aging unit is given an opportunity to work with Ombudsman, residents and their families during the relocation process.

Bureau of Developmental Disabilities Services

BDDS Central Office (CO) receives notification from BQA regarding facilities that are downsizing or closing. BDDS reviews a copy of the relocation plan to identify persons with developmental disabilities who may be affected by the closure/ downsizing. A crosscheck of the most recent FLCIS report is done to determine if any individuals are missing from the facility listing. In addition, BDDS contacts the PASARR Administrator in the Bureau of Community Mental Health to determine whether the PASARR database identifies individuals not noted in the facility listing or FLCIS report. The PASARR database also aids in identifying individuals with developmental disabilities who may or may not need specialized services (active treatment). This is useful when BALTCR, BCMH, BDDS and counties (including Family Care Resource Centers and Care Maintenance Organizations) begin the work of determining which target group and support system will most appropriately serve the person.

BDDS CO contacts the BQA Relocation Specialist to provide initial feedback about the relocation plan and offers any recommendations related to the plan. BDDS CO also contacts the regional Community Integration Specialist(s) assigned to the county where the facility is located.

An individual's county of legal residence, even if different from the location of the facility, retains primary responsibility for developing and funding community supports. The CIS works as a team member with the county, OSF-AAA, BQA regional staff and other program bureaus to help individuals and their families understand options and opportunities related to community supports for people with developmental disabilities. This may include attending relocation team meetings to provide information about community waiver programs administered by BDDS as well as providing other technical assistance support as needed.

BDDS works with counties as to the availability of community waiver funding. BDDS communicates with other bureaus and divisions to explore other available funding options (i.e., with BALTCR regarding COP high cost funds or with the Division of Health Care Financing regarding enhanced waiver rates related to downsizing/closure activities).

BDDS works directly with counties involved in moving a person with a developmental disability from a nursing home or an Intermediate Care Facility serving people with Mental Retardation (ICF-MR) into a community placement with Medicaid waiver funding and Community Options Program Services. If no slot is available, continue to work with the county to secure placement.

Bureau of Mental Health and Substance Abuse Services

Bureau of Mental Health and Substance Abuse Services (MHSAS) Responsibilities:

MHSAS staff cross-reference the list of persons to be relocated to the Preadmission Screening and Resident Review (PASRR) database. The PASRR process is based on federal law and requires the state to determine the following: if persons who have a mental illness or developmental disability need nursing facility placement, and/or if these persons need specialized services to increase independent functioning that currently is limited, due to the mental illness or developmental disability. Persons who are determined through the PASRR process to not need nursing facility placement are to be discharged to a community placement under most circumstances.

MHSAS staff also offers limited consultation and assessment services to help determine the needs and treatment approaches for persons who have a mental illness and who may benefit from a community placement or who have not responded well to treatment. MHSAS is to encourage and assist county participation in the relocation of persons with mental illness from the facility to a community placement or from one nursing home to another nursing home.

Office of Strategic Finance - Area Administration

The Area Administration's (Regional) Role

Regional Office staff from the Area Administration teams have a supportive role in facility closures. The role for OSF is to help ensure compliance with the timetables and conditions set out in Chapter 50 for closures. Additionally, the Regional staff may determine the need for and call for other divisional resources to effect a safe and efficient transition for affected residents.

For Residents and Families

- The Regional Office does not have an active role with residents and families.

For Facility and County Staff

- The Regional Office will participate in the weekly relocation planning meetings as needed, facilitating contact with the Program Bureaus for technical assistance and funding when needed.

- The Regional Office will assist the county in program planning, with and emphasis on assuring health and safety needs are being met in the least restrictive environments.

County Model

NOTE: Although, Milwaukee County staff developed the language for this document, it is acknowledged that each county is organized differently. This information can be used as a model for other counties.

I. Department on Aging:

1. Meet with NH administrators/staff and ombudsmen about discharge planning. Attend the initial meeting with the ombudsmen to inform staff about our programs and services as well as to let them know with whom they would be dealing.

2. Attend the Family/Resident conference to inform all about our programs and services as well as what we will be doing in the days ahead.

3. Send a team of RN's and Social Workers to the facility within 10 days of notification of closure to meet with every resident over the age of 60 to determine his/her potential or preference for relocation, to gather info about guardianship or protective placement orders (existing and potential) and to get current medical info.

4. With information gathered in Step 3, determine our current or previous activity with the individual, generate a case record and assign staff to each individual requesting community placement.

5. Attend weekly meetings convened at the facility by the Regional Office to answer concerns of NH staff, provide an update on progress to date and to hear a report from NH staff as to relocations to other facilities they may have.

II. Role of Adult Services Division-DD/PD Section

For Residents and Families

Adult Service Division – Disability Staff will:

Participate in the initial closure/informational meeting in collaboration with State staff, nursing home administration, and advocacy, personnel related to the relocation process, by providing information on Adult Service Division and it's role in the closure process.

Host or organize small group meetings, if necessary, to discuss disability services and community resource personnel.

Complete individual assessments, functional screen and health forms on residents with PD and DD conditions, to develop recommendations for relocation alternatives.

Be available to answer questions of clients/residents, guardians and family members on service issues related to community services.

Participate in relocation/option meetings to discuss with resident, guardian and family community alternatives, if appropriate.

Facilitate information to, and collaborate with, facility staff on appropriate community resources for the resident to tour, if desired.

Assign a case manager to identify individuals meeting criteria for, and interested in, community placement.

For Facility Staff

Adult Service Division – Disability Staff will:

Provide information to staff on Adult Service Division organization and service system.

Provide information on the role and process of Adult Service Division staff related to facility relocation and closure.

Discuss with assigned facility staff functions, process and responsible parties to address alternative community services via ASD personnel.

Collaborate with facility staff on alternatives, recommendations and discharge planning of all PD and DD residents under 60 years of age.

III. Role of Mental Health Division

1. To initiate the process of discharge planning and relocation of residents associated with a nursing home closure, staff of the Mental Health Division will meet with:
   - the Nursing Home Administrator/ Staff
   - the Relocation Team
   - Staff of the Wisconsin State Regional Office
   - Advocacy and Ombudsman personnel and
   - Staff from Milwaukee County Adult Services Division

2. Milwaukee County Mental Health Division Staff will assess clients who are between the ages of 18 and 59 ½ years and have severe mental illness by:
   - Meeting with the client
   - Contacting the family or guardian
   - Communicating with Nursing Home personnel when appropriate and
   - Referring to applicable medical records

3. Milwaukee County Mental Health Division staff will make recommendations for appropriate placement possibilities based on:
   - Assessments accomplished in #2 above
   - Desires of the client and guardian or family and
   - Consideration for the safety of the resident and reasonability

4. Milwaukee County Mental Health Division staff will be available to clients and family members or guardians to:
   - Assist in getting information regarding resources
   - Assist with answering any questions they may have

5. Milwaukee County Mental Health Division staff will attend scheduled meetings at the facility/ Nursing Home to exchange current information regarding:
   - Progress of closure of the facility and
   - Discharges and relocation of the clients/ residents

Facility's Role

- Submit updated information on the facility's progress in relocating residents to BQA according to the frequency established in the formal BQA approval letter.

- Submit weekly reports on all resident transfers, discharges to community or hospital, and deaths. Include status of the relocation process as it pertains to particular residents, or cases involving unresolved or pending guardianship issues to BQA. The BQA Relocation Team Coordinator will distribute reports to other team members as appropriate.

- Document in each resident's care plan the changes and adjustments in care, treatment and the activities of daily living, necessary for the resident to make a successful transition to a new placement and to ameliorate the negative affects of relocation.

- Notify BQA when the last resident has left the facility. Return license to BQA, with a complete listing of discharges (date and where relocated to).

Voluntary Termination of a Skilled Nursing Facility (SNF) or Nursing Facility (NF)

7500 Security Boulevard
Baltimore, MD 21244-1850

III. Ref: S&C-02-23

DATE: April 29, 2002

FROM: Director
Survey and Certification Group
Center for Medicaid and State Operations

SUBJECT: Voluntary Termination of a Skilled Nursing Facility (SNF) or Nursing Facility (NF)

TO: Associate Regional Administrators, DMSO
State Survey Agency Directors

The purpose of this memorandum is to identify the responsibilities of The Centers for Medicare & Medicaid Services (CMS) under the Social Security Act (the Act) and the regulations when a SNF or NF voluntarily terminates from the Medicare/Medicaid Programs.

VOLUNTARY SNF TERMINATIONS

When a SNF voluntarily terminates from the Medicare program, the general provider regulations at 42 CFR §§489.52 and 489.55 as well as the SNF regulations at §483.12 (a)(5)(6) apply (see also section 1866(b)(1) of the Act. In addition, there are several State Operations Manual (SOM) sections that address voluntary terminations. These include SOM sections 3008-3008.3, 3036, 3038, 3042, and 3046-3048. There are also model letters for voluntary terminations at Exhibits 188 and 189 in the SOM.

A voluntary termination may be a business closure or cessation of services to the community, or simply a withdrawal from the Medicare program. The withdrawal may be the SNF's way of avoiding a proposed involuntary termination or it may be requested because of dissatisfaction with the Medicare reimbursement amount or for some other reason.

The provider is required to give CMS a 15-day notice prior to voluntarily terminating its agreement, but this does not always happen. If the provider's notice does state the intended date of termination, this date must be the first day of a month, as determined by the regional office.

If no date is specified in the notice or the date is not acceptable to CMS, CMS may set a termination date that will not be more than 6 months from the SNF's notice of intent. CMS may accept a date that is less than 6 months after the notification date if it determines that to do so would not unduly disrupt services to the community or otherwise interfere with the effective and efficient administration of the Medicare program.

In establishing a date of termination, CMS will consider the availability of other facilities in the area. If a retroactive termination date is requested, CMS may honor such a date if there were no Medicare beneficiaries who received services from the SNF on or after the requested termination date. If there is a facility closure, the closure date is the termination effective date.

The withdrawing SNF is required to give notice to the public at least 15 days before the effective date of Medicare termination. The notice must be published in one or more local newspapers and must specify the termination date and specify what services it will continue after that date. There may be circumstances where the SNF is unable or unwilling to give public notice, such as a retroactive termination. In such a case CMS will provide the public notice. In a voluntary termination, CMS is not required to provide notice of an Administrative Law Judge hearing. However, if the SNF protests the voluntary termination of its agreement you may rescind the termination since it obviously would not be "voluntary" at that point. Then, if you want to convert it to an involuntary termination, hearing rights would accrue. In accordance with 42 CFR §489.55, payment may be made to a SNF for services furnished to a Medicare beneficiary for up to 30 days after the effective date of the termination if he/she was admitted before the effective date of the termination. Medicare will not pay for services to beneficiaries admitted on or after the effective date of termination.

If the facility continues to remain open, in accordance with 1866 of the Act, it cannot legally charge an individual or any other person for services the person is entitled to have Medicare pay for under the Act.

Although Section 1819(c)(2)(A) (C) of the Act and its regulatory counterpart at 42 CFR §483.12(a) which concern a resident's admission, transfer and discharge rights, may not have been intended to address voluntary withdrawal situations, they nevertheless apply when a SNF voluntarily withdraws from the Medicare program. This is so because the Medicare withdrawal or closure resulted from an action by the facility, and residents may choose to be transferred (moved to another legally responsible institutional setting) or discharged (moved to a non-institutional setting) from the facility since they are no longer protected by the terminated Medicare agreement or because the SNF is no longer serving the community. The regulations require that a SNF resident and, if known, a family member or legal representative of the resident be notified in writing at least 30 days prior to the discharge that the facility is transferring or discharging him/her because it is closing or it is voluntarily withdrawing from the Medicare program (ceasing to operate as a SNF).

In an imminent closure situation the notice should be provided as soon as possible because the resident will lose protection derived from the facility's Medicare participation. Medicare does not make payment to a resident located in a Medicaid only nursing facility (NF). Additional information is provided concerning the notice at section 1819(c)(2)(A) - (C) of the Act, 42 CFR §483.12(a) and the Medicare Interpretive Guidelines. In a situation where a facility closes its doors to the community there is no way that we can enforce these transfer and discharge protections following the effective date of its termination. If patients are abandoned you may, however, notify the Office of the Inspector General. Facilities are required as a part of the resident's notice to inform him/her of the name, address and telephone number of the long-term care ombudsman.

Regardless of what role the state survey agencies are allowed to play in voluntary SNF terminations, CMS remains ultimately responsible for responding to matters arising from these terminations. The state, however, is responsible for patient transfers in these cases.

VOLUNTARY NF TERMINATIONS

The regulation at 42 CFR §431.107(b) requires a NF, among other Medicaid providers, to have an agreement between the NF and the Medicaid agency in which the provider agrees to comply with specific requirements identified in the regulation. See also section 1902(a)(27)(28) of the Act. However, the Medicaid regulations at 42 CFR §442 ff. that address agreements do not address termination of those agreements, but refer to subpart E of Part 488 for NFs (42 CFR §442.12(c)). Subpart C of Part 488 does not discuss voluntary terminations either, although there is a discussion of the termination of provider agreements at subpart F of Part 488 at 42 CFR §488.456. However, this regulation discusses, among other things, involuntary rather than voluntary terminations of the provider by the state. Also, the regulation at 42 CFR §441.11 allows for Federal financial participation to continue for a resident for up to 30 days following the effective date of a facility's voluntary termination of its Medicaid agreement as a NF.

42 CFR §483.12(a) requires a nursing facility to provide at least 30 days notice to a resident, and if known, a family member or legal representative of the resident before transferring or discharging him/her. The regulations and interpretive guidelines specify other documentation and requirements that must be met prior to transferring or discharging a patient. The terms transfer and discharge have the same meaning for NFs as they do for SNFs. Among the reasons a NF might legitimately transfer or discharge a patient is it ceases to operate (as a NF) (42 CFR §483.12 (a) (2) (vi)).

Section 1919(c)(2) (A) - (F) of the Act specifies what happens to NF residents when there is a transfer or discharge of a resident. Some of these statutory requirements could come into play when the facility closes or voluntarily terminates from the Medicaid program.

In particular, section 1919(c)(2)(F)(i)(I) of the Act states that in the case of a NF that voluntarily withdraws from participation in a state plan but continues to provide NF type services, the voluntary withdrawal is not an acceptable basis for discharging or transferring residents of the facility on the day before the effective date of the withdrawal (including those residents who were not entitled to medical assistance as of such day). These provisions continue to apply to the residents until the date of their discharge from the facility. In the case of each individual who begins residence in the facility after the effective date of its withdrawal, the facility must provide notice orally, and in a prominent manner in writing, (on a separate page from other documents signed by the individual) at the time he/she begins residence.

The written notice must include: (1) a statement that the facility is not participating in the Medicaid program; and (2) a statement that the facility may transfer or discharge the resident from the facility when he/she is unable to pay the charges of the facility, even though the resident may have become eligible for medical assistance for nursing facility services under Medicaid.

At the time the individual begins residence at the nursing facility the aforementioned information must be provided by the facility, and the facility must obtain a signed acknowledgment from the individual in writing that he/she was given notice of the non-participation and discharge information previously discussed. The signed acknowledgement must be separate from other documents signed by the resident.

With respect to individuals who were residing in the facility on the day before its voluntary withdrawal (including those who were not entitled to medical assistance of that date), the facility is deemed to continue under the state plan after the effective date of the facility's voluntary withdrawal from the state plan for the purposes of: (1) receiving payments under the state plan for nursing facility services provided to such residents; (2) maintaining compliance with all applicable requirements of Title XIX; and (3) continuing to apply the survey, certification and enforcement authority provided under 1919(g)(h) of the Act including involuntary termination of a participation agreement deemed continued after its voluntary termination. This deemed continuance does not apply to individuals who become residents after the facility's effective date of voluntary withdrawal from the Medicaid program. The voluntary withdrawal provisions apply to those withdrawals occurring on or after March 25,1999.

Section 1919 (c)(2)(F) of the Act is self-implementing. There are no implementing regulations. A facility's decision to voluntarily withdraw from the program does not in any way alter the resident protections offered at section 1919(c)(2)(A) - (D) of the Act and 42 CFR §483.10(o), and 42 CFR §483.12 of the regulations. Of course if a facility ceases to provide services to the community we cannot force it to remain open to provide services to its residents. These residents must be discharged or transferred.

Section 1919 (c)(2)(F) of the Act also neither addresses distinct parts nor changes the distinct part policies discussed at Section 3202 of the SOM. These instructions remain intact and apply to Medicaid NFs. The policies are to be followed by the state when a voluntarily terminated NF attempts to change its number of beds (See also 42 CFR §440.40).

The State Medicaid Agency is responsible for the welfare of residents affected by a voluntary closure of a NF. SOM section 3008.3 provides guidance concerning relocating patients displaced by termination (including voluntary termination) or closure. It explains that each state is expected to have a plan that describes the relocation of patients, and informs as to what CMS believes the plan should provide for. Additionally, in accordance with section 1819(c)(2)(B) (iii)(II) of the Act, the notice to residents is to include information as to how to contact the ombudsman who is established under the Older Americans Act.

Effective date: This guidance is effective immediately.

Training: This memorandum should be shared with all survey and certification staff, surveyors, their managers, the state/regional training coordinator and the Medicaid state agency.

/s/
Steven A. Pelovitz

Relocation Best Practices

for

Discharging and Receiving Facilities

Wisconsin
Bureau of
Quality Assurance

www.dhfs.state.wi.us

www.wisconsin.gov

Bureau of Quality Assurance (BQA)
Relocation Best Practices

The closure of a nursing home, facility serving people with developmental disabilities or a community based residential facility is a stressful time for both residents and family members. Over the past several years, BQA has compiled a number of Relocation Best Practices that, if followed, should help ease the transition for relocating residents and concerns of their families. This information is posted on the Department of Health and Family Services (DHFS) internet web site at www.dhfs.state.wi.us; in addition the Relocation Best Practices are distributed to facilities affected by closures or downsizing. We acknowledge the assistance of Healthcare Management & Diagnostics (HMD), Ombudsman, county staff and state staff from many bureaus within the DHFS, Division of Disability and Elder Services (DDES) in compiling this document.

When a facility announces that it is closing or relocating a number of residents, it is imperative that all parties involved work together to develop a client centered relocation plan. The facility and it's staff, the residents, family members and guardians, involved county agencies, Ombudsman, advocates, other facilities (both nursing home and community settings) and the various agencies within the DHFS are key players in effecting a positive relocation with the resident. Although each party may have a different interest in the relocation (financial, welfare of residents, etc), each party becomes a member of the relocation team collaborating to make the relocation as successful an experience as possible for all concerned.

The list below reflects Relocation Best Practices that, if followed, can help ensure a successful relocation:

1. **Resident Focused**: Any relocation effort must first and foremost be client centered. Maintaining a resident focus brings a level of knowledge of resident needs and preferences, family issues and community resources that are invaluable to the overall relocation planning. The relocation team needs to appreciate and respect the resident/families' choices and options. A thorough discharge planning with resident and family involvement is vital.

2. **Meetings**: Face-to-face regular meetings with all of the different people, entities and agencies involved in the relocation efforts are essential. It is critical to have an initial in-person meeting where roles and responsibilities are clarified and discussed for each team member. Additional meetings keep the relocation planning on track and resident focused, and enhances problem solving and communication flow. The relocation team meetings need a facilitator/leader and team members who are present and/or involved on a regular basis.

3. **Communication:** Continual, positive and consistent communication throughout the relocation process is a key factor. Information needs to be shared timely and regularly with all involved, including relocation team members, resident, family and community (support from the community including spiritual/religious supports, family, friends, etc. is beneficial). It is important to have a primary communication contact that will share information as well as coordinate and lead problem resolution and decision making efforts.

4. **Problem Resolution:** Problems need to be identified and resolved as soon as they are known. Weekly or more regular relocation team meetings may need to occur in the early stages of the relocation process. Questions/issues need to be shared with team members and referred to appropriate persons and dealt with in a timely fashion.

5. **Teamwork**: The relocation team consisting of facility staff, county representatives, Ombudsman and other advocates, state central office and regional office staff, along with residents and their guardians, needs to be well synchronized in the goals for closure and the residents' optimal well-being. Openness and willingness of all to work together to reach the final positive objectives for each individual resident is imperative Team members must clearly define their roles, stick to them and hold the other team members/partners accountable. Cooperative teamwork among all of the relocation agencies is important to solve problems,

think creatively for challenging situations and to identify appropriate choices and options for resident input.

6. **Education:** Education regarding the relocation process by DHFS and county staff to facility, resident, family and community is essential. Information and education on resources available to relocate residents into the community through CIP slots and other funding mechanisms. Allows for choices and options to meet residents needs and preferences. In addition, relocating residents may need guardianships to be established or other forms of advance directives to be activated. Relocation is a time where families may face these issues and may need education and assistance in effecting the appropriate outcome for their family member.

7. **Funding:** Both the county representatives and DHFS staff can provide information relative to the availability of funding sources, the appropriate funding sources and access to the knowledgeable staff who can give direction in providing viable choices for residents.

8. **Ombudsman/Advocate and Liaison Activities:** Liaison activities provided by the Ombudsman and other community advocates during the entire relocation process, with the resident, family members, county, and state regional and central office staff is critical. Ombudsman and county advocates knowledgeable of the systems, players, surrounding nursing homes, CBRFs and other community resources are significant assets to successful resident relocation.

9. **BQA and Other DDES Bureaus' Involvement:** BQA and DHFS staff experienced in the relocation process and outcomes are essential to provide education and consultation to everyone involved in the relocation process, including information on each player's roles and responsibilities. Staff may include individuals from the Bureau on Aging and Long Term Care Resources (BALTCR), the Bureau for Developmental Disabilities Services (BDDS) and the Bureau of Mental Health and Substance Abuse Services (BMHSAS). BALTCR/BDDS/BMHSAS staff can provide important information and education on community placement options and resources to meet resident preferences. These staff also assist by providing access to specialty clinical consultation, including helping to resolve medical/clinical disagreements. BQA/PRQI (Provider Regulation and Quality Improvement) staffs provide facilitation of the relocation team efforts, helping to keep the focus on the resident, facilitating problem solving and issue resolution and keeping the efforts on track.

10. **Facility Staffing and Activity Programming:** Appropriate facility staffing levels must continue throughout the relocation process. Resident activity programming, until the closure date, permits the remaining residents to be active physically, emotionally, spiritually, cognitively and socially.

11. **Transitioning:** Once the resident and family have decided where the person will relocate to, helping the resident successfully transition to his/her new home is an equally important activity of both the sending and the receiving facility. This responsibility involves ensuring that the person's new staff know and understand the person's skills, needs and interests, allowing the person to visit his/her new setting, being available to answer questions that may arise, etc. More best practice relocation items for both the relocating and receiving facilities to enact a successful transitioning are located on the following pages. Planning for helping the remaining residents deal with the losses and emotions that come with observing others leave is a major responsibility of the discharging facility

Follow Up: Resident follow along after relocation is essential to effect a positive transition of residents. In addition, information gathered during the follow along process provides valuable insights into improving future relocation efforts.

The following pages contain Relocation Best Practice suggestions, to implement during a facility downsizing or closure. Following these suggestions will assist in making resident transitions smoother and will also help mitigate the effects of transfer trauma.

RECOMMENDATIONS FOR THE DISCHARGING FACILITY:

Preparation:
- Begin relocation preparation and planning as early as possible.

Notification:
- Inform residents, family and staff of the closure or downsizing decision as soon as possible and at the same time, if possible.
- Give the same message to everyone.
- Utilize known staff, pastoral care and social services to inform and support the residents.
- Utilize these same resources to inform and support the staff.
- Inform residents verbally to enhance feeling of caring by the staff. (It is preferable to inform residents verbally before the required 30 written notice is given to them.)
- Inform residents in writing to provide a clear message and concrete details.
- Notify volunteers, pastoral care and other facility regulars.
- Inform community and press. This is an important aspect that is sometimes neglected.

Maintain Steady Communication:
Staff:
- Keep staff informed with up-to-date accurate information. Establish periodic informational meetings; in the beginning daily, then weekly or more as needs arise. Publish periodic printed updates so all shifts can be kept informed.
- As staff has the most contact with residents, make sure they transmit the appropriate information accurately in a calm and factual manner.
- Although successful relocation is the responsibility of all staff, assign one person to be in charge of assuring that placement decisions are made, families and guardians are kept aware and transitioning plans are in place.
- Establish stress reduction options for staff including training, quiet space, printed materials, etc.

Resident:
- Visit with each resident as frequently as his or her health and cognitive status permits to provide support and allay each resident's concerns. Continue these visits throughout the process.
- Provide residents with opportunities to ask you questions. Answer them thoroughly and promptly.
- Encourage family or significant others and residents in the continuing dialogue through frequent and on-going group meetings or individual discussions to answer questions about the process and provide continuing information and emotional support. Provide periodic printed updates to keep all informed of developments and progress.
- Establish and encourage stress reduction options.

Education:
- Provide staff inservice on Relocation Best Practices. This should be directed to the entire staff including administration, management, volunteers and others regarding potential effects of transfer trauma as it relates to continuity of care, staff attitude and positive resident outcomes.
- Consider providing information on Relocation Best Practices to residents and family, to assist with self-awareness and assistance to families in giving appropriate support to residents.
- Include in the inservice discussion each individual staff's role in effecting positive relocation outcomes for each resident.
- Staff attitude and their ability to put resident needs for calm and security before their own needs is crucial to this life-changing event.

Atmosphere:

- Identify potentially contentious and emotional atmospheres surrounding closure. Protect residents from these effects.
- Make the relocations an opportunity for new experiences and the awakening of new interests.
- Turn the closure into a memorable event, not a somber one.
- Maximize the positive, not the negative. Identify the gains as well as the losses in the experience.
- Remind staff to foster positive feelings in residents, highlight the opportunities presented at the new facility, e.g. new activities, new friends.
- Ensure that all staff is open to and even probes for questions and feelings of the residents as the process moves along.
- Provide for staff support, venting, and assistance with concerns. This needs to be done in a safe and confidential environment. Staff should avoid venting with each other in front of residents or public areas.
- Be sensitive to the emotions that will be felt by the residents who remain in the facility while others are moving out.

Solicit, Develop and Make Available Information Regarding New Homes:

- Inform residents of all choices. The more information families and residents have about potential new homes, the lower the anxiety level will be.
- Use every communication device available: film strips, photos, literature (brochures, pamphlets, newsletters), Internet web sites.
- Have staff from new facilities available for residents and families to talk with. (But do not allow other facilities to "shop" for residents in your facility.)
- Develop buddy systems among residents.
- Develop special efforts of volunteers.

Visits/Tours/Transition:

- Solicit assistance from admitting facilities in setting up and facilitating the tours.
- Arrange for tours for both residents and their families/guardians. If families/guardians are not available, send a trusted staff person or friend along.
- Provide touring of different facilities, allowing choice, affirming that it doesn't have to be the first place that is toured. Residents need to be considered one of the key decision-makers in this process.
- Provide opportunities for the relocating resident to meet residents at the receiving home and vice versa. These efforts will help develop relationships and decrease anxiety. Find out if the relocating resident knows anyone at the receiving home and arrange for them to meet.
- Families and staff need to exchange visits to encourage acceptance and enthusiasm for the move.
- Arrange for repeat tours even after a decision has been made for the move. This will make for a smoother transition. Have the person stay for a meal, an activity, or, if appropriate, an overnight. Decisions about the number of visits must be individualized.
- Have person be involved in packing and unpacking his/her possessions.
- Give consideration to a move with a peer and help coordinate that effort, if possible.
- If moving a longer distance, provide pictures, look at maps, prepare for the trip, discuss needs to stop on the way, explore special needs and fears.
- Bring the change/moving theme into activities.
- Move people earlier in the week; avoid moves on Friday, unless the team has determined otherwise. If the receiving facility has questions or problems, it is more likely they will receive assistance from the sending facility during the week when more staff are present.
- Consider from the start and all along the way, the needs of individuals with cognitive losses. Consider

consultations with a psychologist in developing approaches that are specific to this group, but individualized, too.

- Hold going away parties as friends, peers and staff leave. This is essential for closure and prepares residents for the upcoming move, much as a rehearsal. Create a memory album for the person to take with them.

- Consider weather, time of year, time of day, family availability, needs of admitting facility, etc. in the timing of the move.

Continuity:

- Determine the most at-risk residents, most elderly, clinically unstable, cognitively impaired and any others that can't make their needs known. Provide additional services to these residents, document them and be sure the information gets to the receiving facility.
- Determine what will go into the discharge packet. Update the information on the days just before and the day of discharge. Develop a checklist of items for the packet and other discharge related tasks.
- Develop an Interdisciplinary Care Plan for potential transfer trauma during this process and be sure it is in the discharge packet.
- Provide complete information and documentation for continuity of care. Examine this from the receiving facility's point of view.
- Go the extra mile by getting medical record releases for documentation of recent consultations and hospitalizations.
- Make a personal or phone contact with a key staff member at the new facility.
- Give the facility a name and phone contact so questions or concerns about the care of the new resident can be answered immediately.
- Have a staff or family member accompany the resident. Consider a nurse in the case of a resident with complex care needs due to medical conditions.
- Whenever appropriate, invite staff and volunteers from closing facility or unit to join the staff at the receiving facility or unit.
- Transfer as many possessions as possible in the move and involve resident in all these decisions to help maintain a sense of home and familiarity.
- Ask individual residents about a desire to maintain contact with a staff member or peer and facilitate this.
- Ensure that equipment and devices are in good repair.
- Ensure that a person's funds are transferred with them so that they have access to their money.

Staff Support:

- Support staff during this change. They must support the residents and put them first before their own issues.
- Assist your staff in employment searches. Set up job fairs. Assist them with resume writing and interview skills.
- Have frequent unit/staff meetings to vent their needs and their ideas for relocation success.
- Establish and encourage stress reduction options.
- Have resource materials for staff on relevant topics.

SPECIFIC RECOMMENDATIONS FOR THE RECEIVING FACILITY:

- Provide inservice regarding Relocation Best Practices. This should be directed to the entire staff including administration, management, volunteers and others regarding potential effects of potential transfer trauma as it relates to continuity of care, staff attitude and positive resident relocation outcome. Be sure they understand their role in lessening the potential for transfer trauma.

- Enhance your pre-admission process to reflect the relocating individual, at risk, and as a potentially challenging admission.
  - Treat a relocation admission from a closing facility differently than other admissions. Assume some instability both emotionally and clinically may occur as a result of the relocation.
  - Have staff visit the person in their current facility before they move. They should meet with staff who provide care and services for the person as well as observe them in different settings, e.g. mealtime, activities, work, etc.
  - Designate one person to ensure that the resident, family members and guardian are kept up-to-date on the resident's relocation and that transitioning activities are followed up on.
  - Anticipate the equipment needs of relocating residents and have them in place prior to their admission.

- Nursing Staff admission procedures
  - Obtain a verbal report from a nurse at the discharging facility and document the conversation.
  - Review all physician orders for clarity with a nurse at the discharging facility.
  - Thoroughly read all transfer information, especially as related to unstable conditions, the plan of care and issues around reactions to the move. Communicate with the discharging facility on any and all questions.
  - Document the resident's reactions (emotional, behavioral, cognitive and physical) to the relocation on the admissions assessment.
  - Explore any variances between the relocation reactions assessed by the discharging and receiving facilities and revise the care plan as needed. Discuss with discharging facility. Intervene with physician if necessary.
  - Document all relocation issues on the Initial Plan of Care.
  - Keep in mind that relocated residents are more at risk for falls and other injuries, and a decrease in ability to perform ADLs due to unfamiliarity of interacting with new environment, staff and other residents.
  - Whenever appropriate, invite staff and volunteers from closing facility or unit to join the staff at the receiving facility or unit.
  - Be aware that anxiety can affect function, medical status, cognitive function, interpersonal relationships, as well as emotional well being.
  - Pay special attention to safety related issues.
  - Provide the resident with a routine as similar as possible to the previous experience, if the previous routine was in agreement with the resident.

- Resident transition on the day of admission and following
  - Provide a sensitive and warm welcome to the resident.
  - Encourage family and residents to stay while the person settles in perhaps staying for a meal on the day of admission.

- Assist the resident with unpacking and preference of room decoration and arrangement.
  - Involve the resident council in procedures to welcome relocated residents.
  - Assign a relocated resident a current resident "buddy" to help through the transition.
  - Introduce the relocated resident to peers as he/she is willing or requests.
  - Reassure the resident that important things (like medication) will be the same.
  - Provide the relocated resident with orientation of the facility and programs as soon as the resident is able to manage this. Provide this orientation in stages, if more appropriate for the person.
  - Offer quiet time for the resident to comfortably explore his/ her environment.

- Encourage opportunities for the resident to meet with staff to express feelings and obtain reassurance.